

Minnesota WIC Program
Medical Formula Documentation
Infants Over Six Months, Children and Women

ID #: _____

Return completed form to the WIC clinic or have your patient return the form to the WIC clinic.

Fax #: 952-891-7565 Attention: - Phone #: -

or Mail to: Dakota County Public Health - WIC 14955 Galaxie Ave, Apple Valley, MN 55124

Completion of this form is federally required to ensure that the patient under your care has a medical condition / diagnosis that requires the use of medical formula and/or changes to his/her supplemental food package.

A. Patient Information: *(Complete all)*

Patient's Name <i>(First & Last)</i> :	DOB:
Parent / Caregiver's Name <i>(First & Last)</i> :	Phone #:

B. Health Care Provider with prescriptive authority: *(Please complete all sections)*

Formula Requested:	
Medical Diagnosis:	
<small>(Justifies the prescription of above formula) Pediasure will not be issued for growth concerns unless there is an underlying medical condition.</small>	
Prescribed amount per day: <input type="checkbox"/> Maximum allowable OR oz. per day Tube Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Instructions for preparation: <input type="checkbox"/> Standard dilution <input type="checkbox"/> Other:	
Number of months needed: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> until 1 year corrected age <input type="checkbox"/> Other:	
Supplemental WIC foods will be issued only with your approval. Your patient will receive no food from WIC if the following section is not completed.	
Please check the issuance appropriate for your patient:	
<input type="checkbox"/> All: Provide all the WIC supplemental foods specific to patient's age listed below.	
<input type="checkbox"/> None. Do not provide any foods at this time; issue medical formula only.	
<input type="checkbox"/> Modified: Please add only the foods checked below to my patient's WIC food package.	
Infants (6-12 months)	Children (12-60 months) and Women
<input type="checkbox"/> Infant cereal	<input type="checkbox"/> Eggs <input type="checkbox"/> Peanut butter
<input type="checkbox"/> Infant fruits/vegetables	<input type="checkbox"/> Cereal <input type="checkbox"/> Beans, dried peas & legumes
	<input type="checkbox"/> Fruits <input type="checkbox"/> Whole grains (bread, brown rice, oatmeal, corn/whole wheat tortillas)
	<input type="checkbox"/> Vegetables <input type="checkbox"/> Fish (Exclusively Breastfeeding Moms only)
	<input type="checkbox"/> Juice
	<input type="checkbox"/> Cheese
<input type="checkbox"/> Issue whole milk: WIC provides low fat or non-fat milk for children ≥ 2 years, and women. Patients receiving medical formula who need additional calories may receive whole milk.	
Special Instructions / Restrictions:	

C. Health Care Provider Information: *(Complete all)*

SIGNATURE (Health Care Provider):	Date:
Printed Name (Health Care Provider with prescriptive authority):	<input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> CNM <input type="checkbox"/> DO
Medical Office/Clinic:	
Address:	
Phone #:	Fax #: